

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by our office.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185522

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near - Wye Mills		c. LENGTH OF STAY IN 1b short				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) in a car on highway		d. STREET ADDRESS RFD # 2				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Aug. 29, 1961				
3. NAME OF DECEASED (Type or print) Howard Robinson Cannon		First	Middle			
4. SEX male	5. COLOR OR RACE white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11/30/1926	9. AGE (In years last birthday) 34 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY Koontz Dairy	11. BIRTHPLACE (State or foreign country) Kent Co. Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Emory Cannon		14. MOTHER'S MAIDEN NAME Elsie Robinson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-24-4301				
17. INFORMANT no		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Old Coronary Occlusion				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	C. Rodney Layton			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 8/30/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/61	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE AUG 31 '61	24b. REGISTRAR'S SIGNATURE Arthur E. Kline		

STATE OF CALIFORNIA
MEDICAL EXAMINER CERTIFICATE OF DEATH

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9532

09523

1. PLACE OF DEATH a. COUNTY Queen Annes		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		b. COUNTY Queen Annes		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville - HOME		c. LENGTH OF STAY IN 1b 1d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		d. STREET ADDRESS X		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Reese		First	Middle	Last	4. DATE OF DEATH Coleman	Month August	Day 27	Year 1961
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February, 14, 1880		9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Reese Coleman		14. MOTHER'S MAIDEN NAME Margaret Montague						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Norwood Coleman, Sudlersville, Md.		Address 824		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 541.		DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. Dental		INTERVAL BETWEEN ONSET AND DEATH 1 week				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO Chronic nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Chronic nephritis						
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sudlersville	(County) Md.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Aug 27, 1961 that (I) (we) last saw the deceased alive on Aug 27, 1961 and that death occurred at Sudlersville from the causes and on the date stated above.								
22e. SIGNATURE C. J. DeFoe, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/25/61				
22c. PHYSICIAN'S NAME (Type) C. J. DeFoe, M.D.		22d. ADDRESS Sudlersville Cemetery						
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Sudlersville Cemetery		23d. LOCATION (City, town or county) Sudlersville		(State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Edmund Fellows, Millington, Md.		ADDRESS Edmund Fellows, Millington, Md.		25e. REC'D BY REGISTRAR DATE AUG 31 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9533

CERTIFICATE OF DEATH

Reg. Dist. No. 09524

1. PLACE OF DEATH a. COUNTY Queene Anne		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		b. COUNTY Queen Anne	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Blackiston Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Louisa	Last Coppage
4. DATE OF DEATH	Month August	Day 28	Year 1961
S. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 31-1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Coppage		14. MOTHER'S MAIDEN NAME Sallie Sudler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Gordon Shawn—Queenstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Chronic myocardial</u>			
DUE TO (c) <u>Progression of heart & placidity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) WV	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7/1 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>61</u> , to <u>July 25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>61</u> , and that death occurred at <u>Sudlersville</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Metcalfe</u>		ADDRESS (Street, city or town, state) <u>Sudlersville, Maryland</u>	
PHYSICIAN'S NAME (Type) C. H. Metcalfe		DATE SIGNED <u>Aug. 31, 1961</u>	
22a. BURIAL, CREMATION, REMOVED <input type="checkbox"/>	22b. DATE THEREOF Aug. 31	22c. NAME OF CEMETERY OR CREMATORIUM Sudlersville	22d. LOCATION (City, town, or county) (State) Sudlersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS Church Hill, Md.	24a. REC'D BY REGISTRAR DATE <u>AUG 31 '61</u>
			24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

9534

19525

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Queen Anne's</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>		c. LENGTH OF STAY IN 1b <i>23 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>ALICE</i>	Middle <i>COES</i>	Last <i>COYLE</i>	4. DATE OF DEATH <i>Aug 10 1961</i>	Month <i>Aug</i>	Day <i>10</i>	Year <i>1961</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 26 - 1892</i>	9. AGE (in years) IF UNDER 1 YEAR <i>68 yrs.</i>	10. IF UNDER 24 HRS. Months <i>68 yrs.</i>	11. IF UNDER 24 HRS. Hours <i>0 hrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Medfield Mass</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Coes</i>		14. MOTHER'S MAIDEN NAME <i>Mabel Weeks</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		
17. INFORMANT <i>Captain Deom D. Coyle Centreville Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Hemorrhage (secondary to Carcinoma of Palate</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hours</i>		
Conditions, if any, which give rise to immediate cause (e), stating the underlying cause last. <i>Arteriosclerosis, generalized</i>		DUE TO (b) <i>Carcinoma of Palate</i>				1 year.		
		DUE TO (c) <i>Arteriosclerosis, generalized</i>				5 years.		
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Centreville</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from... saw the deceased alive on... <i>July 10 1961</i>		to <i>August 10 1961</i> , that (I) (we) last and that death occurred at <i>6:45 A.M.</i> from the causes and on the date stated above.						
22e. SIGNATURE <i>John R. Smith Jr.</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>John R. Smith, Jr. MD</i>		22d. ADDRESS <i>Centreville, Maryland</i>						
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 24-61</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		23d. LOCATION (City, town or county) <i>Arlington Virginia</i>		(State) <i>Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Smith Jr. MD</i>		ADDRESS <i>10000 Block of Route 65 Centreville Md</i>		25e. REC'D. BY REGISTRAR DATE <i>AUG 15 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Wm. S. Turner</i>		

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9535

CERTIFICATE OF DEATH

Reg. Dist. No. 118526

1. PLACE OF DEATH a. COUNTY Q. A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stevensville, Md.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stevensville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First Emma	Middle Virginia
4. DATE OF DEATH		Month Aug.	Day 25
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 1880		9. AGE (In years from last birthday) 80	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Smith	
14. MOTHER'S MAIDEN NAME Henry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Oscar Heath	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 232X		Address Stevensville, Md.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
DUE TO (c)		Generalized Atherosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1951 to Aug. 1961 , that I last saw the deceased alive on Aug. 24, 1961 , and that death occurred at 79 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Anne Arundel, Md.	
ACTUAL SIGNATURE Irvin G. Hoyt		DATE SIGNED 7/25/61	
PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-61	
22c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cem.		22d. LOCATION (City, town, or county) Stevensville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James S. Dashiell - Boston, Md.		24a. REC'D BY REGISTRAR DATE Aug 31 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE James S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3
should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3
should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. FROM THE PLEASANT HOMES OF THE FAMOUS STAR COMPANY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for filing.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6294 9/6/61 mb

Reg. Dist. No. 09527

1. PLACE OF DEATH
a. COUNTY

Queen Ann's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Centreville

c. LENGTH OF STAY IN 1b

life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

-

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland b. COUNTY Queen Ann's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Centreville

d. STREET ADDRESS

1306 Little Kowell

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED
(Type or print)

First
John

Middle
Johnson

Last

4. DATE OF DEATH

Month Aug Day 29 Year 1961

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

1910

9. AGE (In years
last birthday)

51 yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

1. Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Canning

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Lottie Moody

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

165-14-0467

17. INFORMANT

Charles W Hard-Centreville

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

—

Arteriosclerosis

Years

19. MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

C. R. Layton

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

C. R. Layton

Aug 29, 1961

22a. BURIAL, CREMATION,
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county)
Burial 9-2-61 Chesterfield Cem Centreville, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

James W. Dossell-Estate, Md. SEP 1 '61 Arthur S. Trahan

ВІДПОВІДЬ НА ВЪПРОС ТВІРЧОГО СТАТУСА ПІДІМІСЬКОГО СТАДІОНА

ІНСАРУЮЩІ ІМІМІСЬКІ ЗАДІЯНИ

2002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9537

CERTIFICATE OF DEATH

Reg. Dist. No.

09528

TO HOSPITAL _____: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Pearl	Middle	Last Pierson	4. DATE OF DEATH	Month Aug.	Day 27	Year 1961	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28 - 1898		9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DAVID SMITH		14. MOTHER'S MAIDEN NAME WILHELMINA Booker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT THOMAS Pierson - GRASONVILLE		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of the cervix DUE TO cause (c) 6 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CENTREVILLE		(County) Md.	(State) M.D.
21. I certify that I attended the deceased from July , 1961, to Aug. , 1961, that I last saw the deceased alive on Aug. 27, 1961 , and that death occurred at Queenstown, Md. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Queenstown, Md.									
ACTUAL SIGNATURE Irvin G. Hoyt									
PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 29		22c. NAME OF CEMETERY OR CREMATORIAL CHESTERFIELD		22d. LOCATION (City, town, or county) CENTREVILLE			
(State) M.D.									
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane - Church Hill, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1 FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09529

1. PLACE OF DEATH

a. COUNTY

Queen Anne's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Grasonville Md

c. LENGTH OF STAY IN lb

1.70

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

None

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Aug 22 1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

420.1 DUE TO

Conditions, if any, which

give rise to immediate cause

(e), stating the underlying

cause last.

(b) DUE TO

(c) DUE TO

19. WAS AUTOPSY
PERFORMED?

YES NO

INTERVAL BETWEEN
ONSET AND DEATH

—

20e. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE AUG 25 '61

Arthur S. Thorne

VS. A15ME

5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (1950)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown, Rural		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101-4	
3. NAME OF DECEASED (Type or print) Daniel Wilton Stewart		d. STREET ADDRESS 330 Grantly St	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Aug. 12 1961	
5. SEX M		6. COLOR OR RACE C	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-19-58	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Dores Stewart		14. MOTHER'S MAIDEN NAME Lee Esther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT None Daniel D Stewart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		Cerebral hemorrhage Fractured skull 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident	
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. Aug. 12 1961		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> at work Route 301 near Queenstown 20f. (City or town) (County) (State) Q.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Irvin G. Hoyt M.D.	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Irvin G. Hoyt MD	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Queenstown, Md.		DATE SIGNED 8/12/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-61	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn		22d. LOCATION (City, town, or country) Balt. Md.	
23. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.		24a. REC'D BY REGISTRAR AUG 17 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
VS. A15ME 5M 7/59		DATE	

CLASS TO STATE-STATE CHARTER
CLASS TO STATE CHARTER 266

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9540

CERTIFICATE OF DEATH

19531

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) near BARKLEY		d. STREET ADDRESS Mr. BARKLEY	
e. NAME OF DECEASED (Type or print) Victor H. TRIBBETT Sr.		First Victor	Middle H.
3. NAME OF DECEASED (Type or print) Victor H. TRIBBETT Sr.	4. DATE OF DEATH AUGUST 9 1961	5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH JAN. 9, 1888	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (County & State, or foreign country) KENT Co. DELAWARE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JERRY M. TRIBBETT	14. MOTHER'S MAIDEN NAME (UNKNOWN)	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI NONE Victor TRIBBETT Jr Address Church Hill, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		19. WAS AUTOPSY PERFORMED? NO	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420. DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH Carotary occlusion	
DUE TO Quint Arterial occlusion		Chronic respiratory	
DUE TO Chronic respiratory		respiratory	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Privity			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7/20 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> No	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7/20	20f. (City or town) (County) (State) 7/20
21. I certify that (I) (this hospital) attended the deceased from Feb 16 1961 to Aug 9 1961 , that (I) (we) last saw the deceased alive on Aug 7 1961 , and that death occurred at 7/20 M, from the causes and on the date stated above.			
22a. SIGNATURE C. H. Metcalfe		22b. DATE SIGNED 8/10/61	22c. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) C. H. METCALFE		22d. ADDRESS Sudburyville, Del.	
23e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-12-61	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City, town or county) (State) Smyrna, Delaware
24. FUNERAL DIRECTOR'S SIGNATURE J. Wells Evans		ADDRESS Smyrna, Delaware	25e. REC'D BY REGISTRAR AUG 14 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Kuhn

